Patient Information

First Name___________________________ **Date of Birth** ____/_____/____

Last Name____________________ **Social Security No.** _____-_____-____

Marital Status: Single Married Divorced Widow Separated Partner

Sex: Male Female

Race: ☐ American Indian ☐ Asian ☐ Black or African American ☐ Hispanic ☐ Pacific Islander ☐ White ☐ Other ☐ Do not wish to respond

Ethnicity: ☐ Not Hispanic ☐ Hispanic, Latino/a ☐ Other ☐ Do not wish to respond

Language Preference: ☐ English ☐ Other __________ ☐ Do not wish to respond

Home Phone (_____)-____________ Cell Phone (_____)-______________

Work Phone (_____)- ____________ **Email** ___________________________

Best Number to reach you at? _______________________________________

Address ____

City ______________________ **State** __________ **Zip Code** ____________

Emergency Contact

Name_____________________________________

Relationship to Patient ______________________

Address ____

Home Phone (____)- ____________**Cell Phone** (____)- ________________

Primary Insurance

Name of Company____

Claim Address ____

Policy/ ID No. _______________________ **Group No.** _______________

Policy Holder Name ____

Relationship to Patient____

Policy Holder's Social Security No. (required) _______-______-________

Policy Holder's Date of Birth ____/_____/_____

Secondary Insurance

Name of Company____

Claim Address ____

Policy / ID No. _____________________ **Group No.** ____________________

Policy Holder's Name ____

Relationship to Patient____

Policy Holder's Social Security No. (required) _______-______-_________

Policy Holder's Date of Birth ____/_____/_____

<u>Person Responsible For Bills (if different than patient)</u>

Name ____

Relationship to Patient ____

Address
____

____

Phone (____)-______________ **Cell** (_____)-_______________________

Does patient have a Living Will or Medical Power of Attorney?

YES (If yes, please provide a copy.) NO

I acknowledge that all of the information given is true and correct and that it has been furnished to this office with full knowledge that the patient is liable for all said services rendered and that he/she is contractually bound to pay for said services.

Patient or Guardian Signature

X____ Date________________